**Name _____ DOB _____ Doctor's Name _____**

**CHIEF COMPLAINT _____ Height: _____ Ethnicity:_____**

**History of Present Illness**

□ Y □ N Contraception
□ Y No Symptoms
□ Y □ N Fatigue
□ Y □ N Headache
□ Y □ N Breast symptoms
□ Y □ N Abdominal pain
□ Y □ N Female Genital symptoms
□ Y □ N Hot flashes
□ Y □ N Pelvic pain
□ Y □ N Menorrhagia (excessive/frequent periods)
□ Y □ N Bleeding between periods
□ Y □ N Dysmenorrhea (painful periods)
□ Y □ N Metrorrhagia (bleeding unrelated to cycle)
□ Y □ N Light bleeding between periods
□ Y □ N Vaginal discharge
□ Y □ N Anxiety
□ Y □ N Depression

## Personal Medical History

**Previous History**

□ Y □ N History of Cervical Dysplasia (abnormal cells)
□ Y □ N History of Human Papilloma Virus
□ Y □ N History of Menopause
□ Y □ N History of UTI ( urinary tract infection)

**LMP, Contraception, and Sexual History**

□ Y □ N First day of last menstrual period_____
□ Y □ N Contraception? What Kind? _____
□ Y □ N Sexually active
□ Y □ N Date of last Pap Smear_____

**Social History**

□ Y □ N Alcohol? If yes, how much? _____
□ Y □ N Tobacco? If yes, how much and for how many years? _____
If no, have you ever been a smoker and for how many years? _____

**Pregnancy Summary**

□ Y _____ Gravida (how many times pregnant)
□ Y _____ Para (how many live children)
□ Y _____ Aborta (miscarriage/elective abortions)

□ Y □ N Recreational Drug use? If yes, how much, and what kind? _____

**Family History**

□ Y □ N Breast Cancer
□ Y □ N Diabetes Mellitus
□ Y □ N Down Syndrome
□ Y □ N High Blood Pressure
□ Y □ N Tay-Sachs Gene
□ Y □ N Colon Cancer

**Prev. Surgical Procedures & Dates _____**

_____
_____
_____

**Current Medications & Dosage _____**

_____
_____

**Allergies(All Types) _____**

_____

## Personal Medical History

□ Y □ N History of Allergic Rhinitis
□ Y □ N History of Asthma
□ Y □ N History of Acute Bronchitis
□ Y □ N History of CAD (heart disease)
□ Y □ N History of CHF (heart failure)
□ Y □ N History of COPD
□ Y □ N History of DM Type II
□ Y □ N Esophagitis Chronic Reflux
□ Y □ N History of Essential Hypertension
□ Y □ N History of Hyperlipidemia (high cholesterol)
□ Y □ N History of Hyperthyroidism
□ Y □ N History of Hypothyroidism
□ Y □ N History of Breast Cancer
□ Y □ N History of Hepatitis
□ Y □ N History of Lumbago (back pain)
□ Y □ N History of Obesity
□ Y □ N History of Osteoarthritis (joints)
□ Y □ N History of PYELO (inflammation of kidney)
□ Y □ N History of Renal Failure
□ Y □ N History of Stroke Syndrome (CVA)

# Review of Systems

**Systemic symptoms**

□ Y □ N Weight change
□ Y □ N Chills
□ Y □ N Fever
□ Y □ N Night sweats
□ Y □ N Feeling tired or poorly
□ Y Other Constitutional symptoms

**Head symptoms**

□ Y □ N Headache
□ Y □ N Facial pain
□ Y □ N Sinus pain
□ Y Other Head-related symptoms

**Otolaryngeal symptoms**

□ Y □ N Earache
□ Y □ N Hearing loss
□ Y □ N Ringing in the ears
□ Y □ N Nosebleeds
□ Y □ N Nasal discharge
□ Y □ N Mouth sores
□ Y □ N Bleeding gums
□ Y □ N Hoarseness
□ Y □ N Throat pain
□ Y Other Otolaryngeal symptoms

**Breast symptoms**

□ Y □ N Breast pain
□ Y □ N Nipple discharge
□ Y □ N Breast lump
□ Y Other Breast symptoms

**Cardiovascular symptoms**

□ Y □ N Chest pain or discomfort
□ Y □ N Fast heart rate
□ Y □ N Palpitations
□ Y Other Cardiovascular symptoms

**Pulmonary symptoms**

□ Y □ N Shortness of breath
□ Y □ N Cough
□ Y □ N Coughing up blood
□ Y □ N Night sweats

**Gastrointestinal symptoms**

□ Y □ N Appetite
□ Y □ N Difficulty swallowing
□ Y □ N Heartburn
□ Y □ N Nausea
□ Y □ N Vomiting
□ Y □ N Abdominal pain
□ Y □ N Diarrhea
□ Y □ N Black or bloody stools
□ Y Other Gastrointestinal symptoms

**Genitourinary symptoms**

□ Y □ N Dysuria (painful urination)
□ Y □ N Increased urinary frequency
□ Y □ N Hematuria (blood in urine)
□ Y □ N Genital lesion
□ Y Other Genitourinary symptoms

**Skin symptoms**

□ Y □ N Pruritus (itching)
□ Y □ N Skin lesions
□ Y □ N Rashes
□ Y Other Skin symptoms

**Endocrine symptoms**

□ Y □ N Excessive sweating
□ Y □ N Excessive thirst
□ Y □ N Libido has changed (sex drive)
□ Y Other Endocrine symptoms

**Neurological symptoms**

□ Y □ N Dizziness
□ Y □ N Vertigo
□ Y □ N Fainting
□ Y □ N Motor disturbances
□ Y □ N Sensory disturbances
□ Y Other Neurological symptoms

**Psychological symptoms**

□ Y □ N Sleep disturbances
□ Y □ N Anxiety
□ Y □ N Depression
□ Y Other Psychological symptoms

□ Other: _____

_____